



**CABINET FOR HEALTH SERVICES**  
COMMONWEALTH OF KENTUCKY  
FRANKFORT, 40621-0001



**DEPARTMENT FOR MEDICAID SERVICES**

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May 10, 2002 <http://www.sysinfo/providerletters.asp>

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Dear Provider:

This letter provides important information about changes to the Medicaid Pharmacy Program, including the implementation of new drug prior authorization (PA) requirements.

**Antihyperlipidemics:**

- **HMG-CoA Reductase Inhibitors (“Statins”):** The following changes are effective June 4, 2002:
  - Lipitor and Lescol will be placed on the Preferred Drug List and will be available without prior authorization, unless quantity limits are exceeded (see below).
  - Pravachol, Mevacor, Zocor, Advicor, and generic lovastatin will require prior authorization and may be approved based on failure of, or medical contraindication or intolerance, to Lescol or Lipitor.
  - All HMG CoA reductase inhibitors except lovastatin 40 mg will be subject to a quantity limit of one tablet or capsule per day unless prior authorization is obtained.
  - Prescriptions for HMG CoA reductase inhibitors written prior to June 4, 2002, and having existing refills may be refilled through August 31, 2002, without prior authorization. PA will then be required.
- **Bile Acid Sequestrants:** The following changes are effective June 4, 2002:
  - Cholestyramine will be placed on the Preferred Drug List and will be available without prior authorization.
  - Colestid and Welchol will require prior authorization and may be approved based on failure of, or a medical contraindication or intolerance to, cholestyramine and a preferred HMG-CoA reductase inhibitor.
  - Prescriptions for bile acid sequestrants written prior to June 4, 2002, and having existing refills may be refilled through August 31, 2002, without prior authorization. PA will then be required.

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- **Fibric Acid Derivatives (Fibrates):** The following changes are effective June 4, 2002:
- Gemfibrozil and fenofibrate will be placed on the Preferred Drug List and will be available without prior authorization.
- Atromid-S (clofibrate) will require prior authorization and may be approved based on failure of maximum tolerated doses of gemfibrozil or fenofibrate.
- Prescriptions for fibric acid derivatives written prior to June 4, 2002, and having existing refills may be refilled through August 31, 2002, without prior authorization. PA will then be required.

**Antihistamines:** The following changes are effective **June 28, 2002:**

- The current antihistamine step-therapy algorithm will be eliminated and the following antihistamines will be available without prior authorization (PA), unless quantity limits are exceeded (see below):
  - Allegra 30 mg, 60 mg, and 180 mg tablets, 60 mg capsules
  - Brompheniramine 4 mg tablets, 2.5 mg/5ml elixir
  - Carbinoxamine 2 mg/5ml liquid
  - Chlorpheniramine 4 mg, 8 mg ER and 12 mg ER tablets; 12 mg ER capsules, 2 mg/5ml syrup
  - Clarinex 5 mg tablets
  - Clemastine fumarate 2.68 mg tablets
  - Cyproheptadine 4 mg tablets; 2 mg/5ml syrup
    - Diphenhydramine 12.5 mg chewable tablets, 25 mg and 50 mg capsules, 12.5 mg/5ml elixir/syrup
    - Nolahist 25 mg tablets
    - Promethazine 6.25 mg/5ml liquid
    - Tripelennamine 25 mg, 50 mg, and 100 mg ER tablets
  - Zyrtec 5 mg and 10 mg tablets, 5 mg/5ml syrup
- Claritin 10 mg tablets and Reditabs & Claritin syrup 5 mg/5ml will be available without prior authorization for children age **2 to 5 years**. PA will be required for Claritin for recipients age 6 years or greater and will require failure within the past 120 days of at least a 30-day trial of Zyrtec, Allegra, or Clarinex.
- Zyrtec 5 mg and Clarinex 5 mg will be subject to a quantity limit of one dosage unit per day unless prior authorization is **obtained**.
- Prior authorization will be required for Claritin-D, Allegra-D, and Zyrtec-D subject to a diagnosis of seasonal allergic rhinitis (SAR) or perennial allergic rhinitis (PAR) and failure of at least a 30-day trial within the past 120 days with Allegra, or Clarinex, or Zyrtec. PA of Claritin-D, Allegra-D, or Zyrtec-D will be limited to a 30-day maximum period unless another PA is approved.
- Prescriptions for Allegra-D, Claritin, Claritin-D, and Zyrtec-D written prior to June 4, 2002, and having existing refills may be refilled through August 31, 2002, without prior authorization. PA will then be required.

**Intranasal Corticosteroids for Allergic Rhinitis:** First-line use of intranasal corticosteroids is becoming an increasingly common treatment for seasonal allergic rhinitis (SAR) and perennial allergic rhinitis (PAR). Intranasal corticosteroids may offer benefits over antihistamines in symptom relief, and unlike the antihistamines, will reduce both the early and late phase responses to allergen exposure. Prior to use of Claritin, Claritin-D, Allegra-D, and Zyrtec-D for SAR or PAR, prescribers are encouraged to consider using a 30-day trial of an intranasal corticosteroid, where clinically appropriate.

**Synagis and RespiGam:** The following prior authorization requirements are effective June 4, 2002, for palivizumab (Synagis) and RespiGam, which are used in premature infants ( $\leq 35$  weeks gestation) for prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV). They are covered for high risk individuals during the months when RSV infection typically occurs. Prior authorization is required and may be approved for recipients with the following indications:

- Recipient is less than 24 months of age at the start of the RSV season (i.e., October) and has chronic lung disease which has required medical treatment (oral bronchodilators or corticosteroids) in the preceding 6 months.
- Recipient is less than or equal to 12 months of age at the start of the RSV season and was born at less than or equal to 28 weeks of gestation.
- Recipient is less than or equal to 6 months of age at the start of the RSV season and was born at 29 to 32 weeks of gestation.
- Recipient is less than or equal to 6 months of age at the start of the RSV season and was born between 32 and 35 weeks gestation and has other risk factors (e.g., neurologic disease in very low birth weight infants).

**Pharmacy Help Desk:** Providers may call the new Pharmacy Help Desk at **800-807-1273** with questions regarding drug prior authorization requests that have already been faxed. Please note that new drug prior authorization requests are not accepted by telephone. The Pharmacy Help Desk is open 6 days a week during the following hours:

Monday – Friday	10:00 AM - 6:00 PM EST
Saturday	11:00 AM - 2:00 PM EST

**Where to Send Drug Prior Authorization (PA) Requests:** The toll-free **fax** number for routine PA requests is **866-863-8803** and for urgent requests is **800-877-2219**. Drug PA requests may be faxed 24 hours per day 7 days per week and except for holidays will be reviewed as follows: Monday-Friday 10:00 AM - 10:00 PM EST, Saturday 11:00 AM - 8:00 PM EST, and Sunday 12:00 PM - 6:00 PM EST. Prescribers are requested to include the pharmacy name and fax number on the drug request form.

**New Nursing Facility Fax Line:** Nursing facilities may now submit drug prior authorization requests to the following fax number: **866-863-9171**. Drug prior authorization requests from nursing facilities will also be accepted if they are faxed to the general or urgent fax numbers listed above. The nursing facility fax line is intended to be used **only** for drug prior authorization requests for recipients in nursing facilities. Please do not send any other drug prior authorization requests to this fax number.

**Obsolete form:** The MAP-122 Drug Prior Authorization/Authorization to Bill, which was previously used as the prior authorization form, is obsolete. Requests submitted on the MAP-122 form will not be accepted.

**New Drugs Available without Prior Authorization (PA):** The following new drugs are now available without PA:

Avelox IV 400mg/250ml	Paxil CR 12.5mg, 25mg, 37.5mg tablet
Arixtra 2.5mg/0.5ml syringe	Pediox 4mt/5ml Liquid
Bextra 10mg and 20mg tablet	Plexion SCT 10-5% cream
Dallergy tablet	Rebif 22mcg/0.5ml and 44mcg/0.5ml
Elidel 1% Cream	Sustiva 600mg tablet
Invanz 1gm	Xenaderm ointment
Neulasta 6mg/0.6ml syringe	Xopenex 0.31mg/3ml
Ortho Evra	Zevalin 3.2mg/2ml
Pamidronate Disodium 3mg/ml vial	

**Internet Web Site:** Medicaid's web site at <http://chs.state.ky.us/dms/> is being expanded to provide more information about the Medicaid Pharmacy Program and related topics such as pharmacy provider letters, Pharmacy and Therapeutics Advisory Committee meetings and recommendations, Drug Management Review Advisory Board meetings and recommendations . You are encouraged to use this web site.

**Questions:** Questions may be directed to the following:

	<b><u>For questions concerning</u></b>	
	<b><u>Contact</u></b>	<b><u>Phone</u></b>
Previously sent drug PA requests	Pharmacy Help Desk	800-807-1273
Billing of pharmacy claims	Unisys provider relations	800-807-1232
This letter or Medicaid policies	Division of Managed Care	502-564-7940

Sincerely,



Marcia R. Morgan  
Secretary